STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00180504 and IN00181061. This visit was in conjuction to the Investigation of Complaint IN00183674. Complaint IN00180504-Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226, F244, F282, F312, F323 and F465. Complaint IN00181061-Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F465. Survey dates: September 30 and October 1, 2, 5, 6, 7 and 8, 2015. Facility number: 000468 Provider number: 155378 AIM number: 100290270 Census bed type: SNF/NF: 102 Total: 102 Census payor type: Medicare: 8 Medicaid: 66	F 0000	The facility requests that this plan of correction be considered it's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 26 Total: 102 Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 21662 on October 15, 2015.			
F 0223 SS=A Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review, the facility failed to prevent a nurse from giving medication to a resident with dementia who was displaying non verbal signs of refusal of medication. (Resident H) Findings include: In an observation on 10/5/15 at 3:45 p.m., LPN #1 was observed passing medications. LPN #1 had medications	F 0223	Brief Description of Incident: Resident was observed in shower room with nurse and C.N.A. Nurse was attempting to administer medication to resident. Resident was observed by ISDH Surveyor swatting at nurse and moving backwards in wheelchair away from spoon with medication on it. ISDH Surveyor stated, “She could not see residents face during the attempted administration of medication.” Nurse did drop some of the medication on resident’s leg and informed her that she would clean	11/07/2015

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	for Resident H in applesauce. LPN #1 pushed Resident H in her wheelchair from the hallway into one of the shower/rest rooms. CNA #2, was cleaning the shower room at that time. LPN #1 had not explained to the resident why she was taking her into the bathroom. Once the resident was in the bathroom LPN #1 told Resident H she had her medication. LPN #1 and CNA #2 were facing the door and the resident was positioned in front of the sink. LPN #1 was observed to take a spoonful of medication and began to put it into the resident's mouth. The medication fell onto the resident's lap and LPN #1 told the resident not to worry about it, she would clean it up later. The resident took her right hand and swatted toward the nurse and started to move backward in her wheelchair. The nurse continued to place the spoon with the rest of the medication in applesauce into the resident's mouth while the resident was moving her head to the right, swatting her hand in the air, and attempting to back up in her wheelchair. The resident was then taken into the hallway outside of the shower room and left sitting in her wheelchair . The resident said, "don't you know?" while shaking her head back and forth at LPN #1 and CNA #2. During an interview on 10/6/15 at 5:08		it up. Nurse then explained she was going to administer more medication, resident said, “no” and then opened her mouth for medication. Type of Injury/Injuries: Mrs. Spears has no observed injuries noted. Immediate Action Taken: Resident interviewed by Social Services to determine if any harm cause by interaction between resident and staff. Resident did not show any signs or symptoms of distress or fear of staff. Jackson suspended pending investigation. Administrator, DoN, Attending MD and family notified Preventive measures taken: Investigation immediately started. MD/Family notified. Nurse suspended pending investigation. Social Service Director will monitor resident x 72 hours for signs/symptoms of emotional distress, care plans reviewed and updated, behavior tracker update to document any occurrences of refusal of care and medications. All staff in- servicing on abuse and resident rights has been initiated. Corrective Action:Nurse was suspended pending investigation. Pain and skin assessment was completed for Resident H with no findings. Administrator, Director of Nursing, family and attending MD were notified. How Others Identified: All residents are at risk Preventative Measures: Staff Development Coordinator will conduct education with return	

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	p.m., the Director of Nursing (DON) and the Administrator were notified of the resident being given medication while the resident was pushing her wheelchair backwards, swatting her hand at staff and pulling her head away when the nurse attempted to give her the medication. The DON indicated at that time the nurse should have stopped trying to give the medication and approached the resident later to give the medication. During an interview on 10/6/15 at 5:15 p.m., the Behavioral Health Manager indicated the resident did not usually refuse care. She indicated she did not like noise and the dining room was where she liked to be, so if there were activities in there she would go hang out in the hallway. During an interview on 10/7/15 at 9:39 a.m., the Administrator indicated he had suspended the nurse pending the investigation. The Administrator indicated the resident had a BIMS (Brief Interview of Mental Status-a test indicating cognitive status) of 3 (cognitively impaired). He indicated the investigative teams' conclusion was the resident had displayed three refusals of the medication, which was she spit her medication out, swatted her hand and pushed her wheelchair back.		demonstration for all nurses on the non verbal signs of refusal of medications for demented residents and appropriate interventions. Monitoring: Med pass audit by the Staff Development Coordinator or designee for residents will be conducted daily for 5 days, weekly for 4 weeks then monthly until 100 % compliance is achieved then quarterly thereafter. Results of the audit wil be submitted to the Quality Assurance/ Performance Committee monthly for monitoring, follow up and further interventions.	

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	On 10/7/15 at 3:15 p.m., the record review for Resident H was completed. Diagnoses included, but were not limited to, dementia with behavioral disturbance and anxiety. The Care Plan for Behaviors dated 9/9/15, indicated no history of refusal of mediations until a hand written note was added on 10/6/15, the day of the refusal. The Care Plan indicated the resident was at risk for wandering, making negative statements, anger, attention seeking and sitting on the floor. The interventions were: "1/24/14. 1) assess for pain 2) Offer reassurance in a calm, slow manner 3) monitor changes in condition and notify MD and family 4) redirect resident to talk about the current events resident likes to read Resident Digest 5) Administer Med's [sic] as ordered. 6) Refer to psych as needed. 7) Allow for safe wandering on unit to ensure resident safety. 8)offer to call her nieces 9) Encourage staff to avoid discussions re: weight as it upsets resident . 7/29/15, 10)Approach from front and make eye contact. Use preferred name and explain all care before and while performing care. 10/6/15, 11) Reproach at later time 12) allow optimal independence with ADL care...."			

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	On 10/8/15 at 8:55 a.m., the Administrator provided the Abuse policy. The "Abuse Neglect and Misappropriation" Policy dated 3/13, with revision dated of 4/13, indicated, "...POLICY A. Verbal, sexual, physical, and mental abuse...of resident are prohibited...." This Federal Tag relates to Complaint IN00180504. 3.1-27(a)(1)			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other			

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	officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident G) Findings include: On 10/01/2015 at 4:49 p.m., the Administrator was notified of an abuse allegation for Resident G. During an interview on 10/01/2015, Resident G indicated an unknown, bald African-American male staff member had hit her twice, causing her to hit her head on the window frame. She indicated he had also yelled at her and called her the devil. Resident G was unable to specify an exact date, but indicated it happened	F 0225	Corrective Action: Abuse investigation is now complete. How Others Identified: 1. All staff were interviewed for any incidents of resident abuse. No further allegations of abuse noted. 2. 5 Residents with BIMS of 10 or more were interviewed on Abuse / Neglect Questionnaire. No allegations of abuse noted. Preventative Measures: 1. Parkwood staff will be educated by the Staff development Coordinator or designee on abuse reporting criteria, investigations and interviewing other staff and residents 2. Investigations will be audited for staff and resident interviewsby Social Services Director Monitoring: Results of ISDH investigations audits will be reviewed monthly at the Quality	11/07/2015

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	when it was warm outside. Resident G indicated she had not reported this to the facility. A record review of the facility investigation of the abuse allegation, completed on 10/08/15 at 4:15 p.m., indicated the facility had interviewed and completed an abuse and neglect questionnaire with five residents during the investigation. No staff members were interviewed. During an interview with the Administrator on 10/08/2015 at 4:42 p.m., he indicated he had not completed interviews with staff during the investigation of the abuse allegation because he had already completed interviews with staff on other investigations over the past 3 weeks. He indicated he had an idea of who the alleged staff member was and felt comfortable this person was gone and further incidents would not occur. A current policy, titled "Abuse, Neglect, and Misappropriation," dated 04/2013, provided by the Director of Nursing on 10/07/15 at 11:03 a.m., indicated, "...V. Protection of the Resident... obtain the staff members witness statement...." This Federal tag relates to Complaint		Assurance / Performance Improvement Committee. Staff and resident interviews are to be included.	

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	IN00180504. 3.1-28(d)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow the policy regarding the investigation of abuse allegations for 1 of 3 residents reviewed for abuse. (Resident G) Findings include: On 10/01/2015 at 4:49 p.m., the Administrator was notified of an abuse allegation for Resident G. During an interview on 10/01/2015, Resident G indicated an unknown, bald African-American male staff member had hit her twice, causing her to hit her head on the window frame. She indicated he had also yelled at her and called her the devil. Resident G was unable to specify an exact date, but indicated it happened when it was warm outside. Resident G indicated she had not reported this to the facility.	F 0226	Corrective Action: Abuse investigation is now complete. How Others Identified: 1. All staff were interviewed for any incidents of resident abuse. No further allegations of abuse noted. 2. 5 Residents with BIMS of 10 or more were interviewed on Abuse / Neglect Questionnaire. No allegations of abuse noted. Preventative Measures: 1. Parkwood staff will be educated by the Staff development Coordinator or designee on abuse reporting criteria, investigations and interviewing other staff and residents 2. Investigations will be audited for staff and resident interviews by Social services Director Monitoring: Results of ISDH investigations audits will be reviewed monthly at the Quality Assurance / Performance Improvement Committee. Staff and resident interviews are to be included.	11/07/2015

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	During an interview with the Administrator on 10/08/2015 at 4:42 p.m., he indicated he had not completed interviews with staff during the investigation of the abuse allegation because he had already completed interviews with staff on other investigations over the past 3 weeks. He indicated he had an idea of who the alleged staff member was and felt comfortable this person was gone and further incidents would not occur. A current policy, titled "Abuse, Neglect, and Misappropriation," dated 04/2013, provided by the Director of Nursing on 10/07/15 at 11:03 a.m., indicated, "...V. Protection of the Resident... obtain the staff members witness statement...." This Federal tag relates to Complaint IN00180504. 3.1-28(a)			
F 0244 SS=D Bldg. 00	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting			

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	resident care and life in the facility. Based on observation, interview, and record review, the facility failed to act upon concerns from the resident council related to the unsafe condition of a public walkway. (Resident R & Resident S) Findings include: On 10/1/15 at 11 a.m., Resident R indicated her church friends, which came to visit told her they were tempted not to come visit as the gaps in the outside outside of the Maplewood unit were dangerous. On 10/1/15 at 2 p.m., Resident S indicated she had noticed the sidewalk outside of the Maplewood area was dangerous and she was worried a resident or visitor would get hurt. Resident S indicated another resident told her it had hurt her when she walked over the large gaps in the sidewalk as they caused her pain when her walker was jolted as she walked over them. On 10/7/15 at 10 a.m., the Resident Council notes were reviewed from April through September 2015. The notes indicated in May, August and September of 2015, the residents discussed concerns with the condition of the sidewalk and patio areas in the Maplewood unit areas.	F 0244	Corrective Action: 1. Plant Operations completed a repair on Maplewood side walk. Please find quote from contractor Indianapolis Concrete and Auto Door and glass for removal and re-installation of Maplewood entrance walk way. 2. Signature HealthCARE purchase order authorizing work to be completed. PO number 102983 How Others Identified: An Audit by Plant Operations was completed of all public sidewalks for safety and no other hazards were identified. Preventative Measures: 1. Plant Operations will submit a monthly audit of public walk ways for safety and hazards to the Quality Assurance / Performance Committee monthly. Any hazards identified will be addressed by Plant operations and Administrator for follow up and intervention Monitoring: 1.Plant Operations will submit a monthly audit of public walk ways for safety and hazards to the Quality Assurance / Performance Committee monthly. Any hazards identified will be addressed by Plant operations and Administrator for follow up and intervention	11/07/2015

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	On 10/8/15 at 9:55 a.m., the Plant Operations Director provided a form dated 3/31/15 titled, " Estimate" from a concrete company. The form indicated an estimate for a sidewalk to be fixed. During an interview on 10/8/15 at 1:35 p.m., the Resident Council President indicated she understood the facility had been aware of these concerns for a while, but she was not aware of the current plan to address the concern. On 10/8/15 at 2:45 p.m., the Administrator observed the sidewalk area outside of the Maplewood unit and the Rehabilitation patio doorway. The sidewalk area was observed to have three cracks, which had uneven concrete surfaces and one with a large crack with in it. He indicated at that time he understood it was a concern and indicated they had plans to work on it next year. This Federal tag related to complaint IN00180504 and IN181061. 3.1-3(l)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN			

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	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the Care Plan for oral care for 1 of 23 residents reviewed for Care Plans. (Resident E) Findings include: On 10/1/15 at 4:55 p.m., a family member of Resident E's indicated she was worried about his teeth as the person who shared the bathroom spent a lot of time in there and she was not sure if staff was able to get his oral care done. During an observation on 10/8/15 at 10:17 a.m., the resident was sitting in the dining room and his mouth had a brown substance around it. The resident's mouth was wide open and his teeth were observed with a brown substance on them. On 10/8/15 at 10:45 a.m., the Care Plan for the resident was reviewed. The 6/18/15, care plan indicated the resident had self care deficits and required extensive/total assistance with daily living tasks. Approaches included: Staff will anticipate the residents needs. Staff would provide verbal cueing for simple	F 0282	**1. How will the corrective action(s) be accomplished for those residents found to be affected by the same deficient practice?** The resident was not identified in the 2567 except by "Resident E". **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** 1. An audit by the Unit Managers the of grooming will be conducted on October 22, 2015 to establish a baseline for educational needs and future monitoring. **3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not reoccur?** 1. Education by the Staff Development Coordinator or designeee to be provided on Oral Care per policy and in compliance with individual Care Plans. 2. Competency's for all Nursing/C.N.A. staff on Oral Care will e provided by the Staff Development Coordinator or designee. **4. How will the facility monitor its performance to make sure that solutions are sustained; that the plan is implemented and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into**	11/07/2015

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	tasks. Attempt to keep resident on task. Praise his efforts (5) Mechanical lift with 2 staff for all transfers. During an interview on 10/8/15 at 10:56 a.m., LPN #3 indicated the aides usually did oral care after meals and more often for someone who was more dependent for oral care. LPN #3 observed the brown residue around the resident's lips and on his top dentures and indicated oral care had not been done recently. During an interview on 10/8/15 at 11:05 a.m., CNA #4 indicated the aides were to document after oral care was completed. She reviewed the Activities of Daily Living for Resident E and indicated the ADL's were blank. This Federal tag relates to Complaint IN00180504. 3.1-35(g)(2)		**the quality assurance system?** 1. An audit by the Director of Nursing or designee of grooming will be conducted daily x 5 days, weekly x 4 weeks, then monthly x 3 months. Audit will be completed Quarterly thereafter until the QAPI committee decides the goal has been achieved.	
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and	F 0312	**1. How will the corrective**	11/07/2015

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	record review, the facility failed to provide oral care to a resident who required assistance with daily living activities for 1 of 3 residents reviewed for Activities of Daily Living. (Resident E) Findings include: On 10/1/15 at 4:55 p.m., a family member of Resident E indicated she was worried about his teeth as the person who shared the bathroom spent a lot of time in there and she was not sure if the staff was able to get his oral care done. During an observation on 10/8/15 at 10:17 a.m., the resident was sitting in the dining room and his mouth had a brown substance around it. The resident's mouth was wide open and his teeth was observed with a brown substance on them. On 10/8/15 at 10:45 a.m., the Care Plan for the resident was reviewed. The 6/18/15, care plan indicated the resident had self care deficits and required extensive/total assistance with daily living tasks. Approaches included: Staff will anticipate the residents needs. Staff would provide verbal cueing for simple tasks. Attempt to keep resident on task. Praise his efforts (5) Mechanical lift with 2 staff for all transfers.		**action(s) be accomplished for those residents found to be affected by the same deficient practice?** The resident was not identified in the 2567 except by “Resident E”. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** 1. An audit by the Unit managers of grooming will be conducted on October 22, 2015 to establish a baseline for educational needs and future monitoring. **3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not reoccur?** 1. Education by the Staff development Coordinator or designee to be provided on Oral Care per policy and in compliance with individual Care Plans. 2. Competency’s for all Nursing/C.N.A. staff on Oral Care by the Staff Development Coordinator or designee.	

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	During an interview on 10/8/15 at 10:56 a.m., LPN #3 indicated the aides usually did oral care after meals and more often for someone who was dependent for oral care. LPN #3 observed the brown residue around the resident's lips and on his top dentures and indicated oral care had not been done recently. During an interview on 10/8/15 at 11:05 a.m., CNA #4 indicated the aides were suppose to document oral care after completed.. She reviewed the Activities of Daily Living for Resident E and indicated the ADL's were blank. This Federal tag relates to Complaint IN00180504. 3.1-38(a)(3)(C)		**4. How will the facility monitor its performance to make sure that solutions are sustained; that the plan is implemented and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?** 1. An audit by the Director of Nurisng or designee of grooming will be conducted daily x 5 days, weekly x 4 weeks, then monthly x 3 months. Audit will be completed Quarterly thereafter until the QAPI committee decides the goal has been achieved.	
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure an outside walkway was in good repair and did not pose a potential safety hazard for 1 of 4 outdoor walkways observed.	F 0323	Corrective Action: 1. Plant Operations completed a repair on Maplewood side walk. Please find quote from contractor Indianapolis Concrete and Auto Door and glass for removal and	11/07/2015

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	(Resident R and Resident S) Findings include: On 10/1/15 at 11 a.m., Resident R indicated her church friends, which came to visit told her they were tempted not to come visit as the gaps in the sidewalk outside of the Maplewood unit were dangerous. On 10/1/15 at 2 p.m., Resident S indicated she had noticed the sidewalk outside of the Maplewood area was dangerous and she was worried a resident or visitor would get hurt. Resident S indicated another resident told her it had hurt her when she walked over the large gaps in the sidewalk as they caused her pain when her walker was jolted as she walked over them. On 10/7/15 at 10 a.m., the Resident Council notes were reviewed from April through September 2015. The notes indicated in May, August and September of 2015, the residents discussed concerns with the sidewalk and patio areas in the Maplewood unit areas. On 10/8/15 at 9:55 a.m., the Plant Operations Director provided a form dated 3/31/15 titled, " Estimate" from a concrete company. The form indicated		re-installation of Maplewood entrance walk way. 2. Signature HealthCARE purchase order authorizing work to be completed. How Others Identified: An Audit was completed of all public sidewalks for safety and no other hazards were identified. Preventative Measures: 1. Plant Operations will submit a monthly audit of public walk ways for safety and hazards to the Quality Assurance / Performance Committee monthly. Any hazards identified will be addressed by Plant operations and Administrator for follow up and intervention Monitoring: 1.Plant Operations will submit a monthly audit of public walk ways for safety and hazards to the Quality Assurance / Performance Committee monthly. Any hazards identified will be addressed by Plant operations and Administrator for follow up and intervention	

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	an estimate for a sidewalk to be fixed. During an interview on 10/8/15 at 1:35 p.m., the Resident Council President indicated she understood the facility had been aware of these concerns for a while, but she was not aware of the current plan to address the concern. On 10/8/15 at 2:45 p.m., the Administrator observed the sidewalk area outside of the Maplewood unit and the Rehabilitation patio doorway. There were several cars that were observed pulling in and out of parking spaces in front of the sidewalk area. The sidewalk area was observed to have three cracks, which had uneven concrete surfaces and one with a large crack with in it. He indicated at that time he understood it was a concern and indicated they had plans to work on it next year. This Federal tag related to complaint IN00180504 and IN00181061. 3.1-45(a)(1)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for			

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	excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to monitor for specific targeted behaviors for the use of antipsychotic medications for 1 of 6 residents reviewed for unnecessary medications. (Resident #10) Findings include: On 10/7/15 at 8:20 a.m., the record review for Resident #10 was completed. Diagnoses included, but were not limited to, seizures disorder, macular degeneration, a history of a femur fracture, dementia and delusional disorder. The Physician's Order Sheet for October 2015, indicated:	F 0329	**1. How will the corrective action(s) be accomplished for those residents found to be affected by the same deficient practice?** A behavior monitoring flow sheet was in place for September and currently in place for delusions/hallucinations. Per regulation: There must be at least one month between GDR of medications unless contraindicated and documented as to why another GDR should be considered. 1. Aug 5th, 2015 Resident was admitted. 2. Aug 17th, Behavior Health Manager (BHM) completed a 48	11/07/2015

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	8/5/15-Seroquel (an antipsychotic medication) 25 milligrams daily by mouth. The physician's orders indicated: 9/14/15-Discontinue Seroquel 25 milligrams and start 12.5 milligrams by mouth. The Physician's Progress notes dated 9/14/15, indicated the resident was on Seroquel and was seen today for a dose reduction. She continued with delusions of convenience as per psych notes. The Physician's Progress notes dated 9/8/15, indicated to be seen by a psych evaluation of dementia and behaviors. The psych note indicated behaviors of confusion, no anxiety. The Physician's Progress notes for August 2015, indicated the resident had psych issues, which included confusion and for the problem list was depressive disorder, anxiety, and dementia with behaviors. The Daily Skilled Nurses Notes from 8/6/15 through 10/1/15 indicated: 8/22/15- behavior of wandering on evening shift 9/5/15- the evening shift indicated delusions, but there was no description		hour Antipsychotic Medication Review. The Nurse Practitioner (NP) was made aware of Seroquel order without appropriate diagnosis. NP recommended that COPE services see resident for evaluation. Social Services began process for obtaining consent for Psych services. 3. Ativan was discontinued on this resident Aug 18th, 2015. 4. Aug 21st, 2015 Pharmacy recommendation to GDR Seroquel 5. Aug 25th, 2015 Order from NP to refer to COPE services for evaluation. 6. Aug 25th, 2015 – BHM completed 14 day audit of resident. 7. Sept 8th, 2015 – COPE services evaluated resident and provided recommendations to GDR Seroquel. 8. Sept 14th, 2015 – GDR written by NP. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** 1. An audit will be completed on all residents by the Behavior Health Manager (BHM) currently on an Antipsychotic and who have a behavior monitoring flow sheet. This will identify all potential residents at risk. 2. Behavior Health Manager	

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	written what delusions were. 9/6/15- evening shift indicated delusions, but there was no description written what delusions were. 9/7/15-night shift indicated delusions, but there was no description of what delusions were. All other documentation since admission had no information indicating the resident had delusions. The Behavior/ Intervention Monthly Flow Record for September 2015, indicated the behavior for Seroquel was Hallucination/Delusions and had Interventions of redirection, which was effective after 3 episodes of delusions on 9/10/15, on evening shift. There were no other documented behaviors. Social Services documentation dated 10/6/15, indicated the resident was delusional as she talked with the resident. The resident appeared delusional as evidenced by reporting she needed to speak with her daughter who was in high school and her sons who were working on the farm, nursing was notified and would follow up at later date. During an interview on 10/7/15 at 10:00 a.m., the Behavioral Health Manager indicated she had no specific information documented on the hallucinations the		will conduct a 72 hour chart review of all new admissions for antipsychotic usage. 3. BHM reviews chart at 14 days with Interdisciplinary Team (IDT) **3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not reoccur?** 1. Educate all nursing by Staff Development Coordinator or designee on Behavior Monitoring Flow Sheets and appropriate documentation by the Behavior Health Manager (BHM) . 2. Behavioral Health Manager & Social Services Director to educate nursing on delusions and hallucinations. 3. Educate nurses on detailed documentation. **4. How will the facility monitor its performance to make sure that solutions are sustained; that the plan is implemented and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?**	

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	resident displayed. She also indicated there were no behavior tracking forms for residents for August 2015. She could not indicate how the resident's delusions exhibited by the documentation on the Behavior/Intervention Monthly Flow Record. A document provided by the Behavioral Health Manager titled, "Behavior Management Program" dated 3/13, with a revision date of 4/13, indicated "...Nurses are to document each behavior each time it occurs, the intervention used, the precipitating factor(s), and the outcome of the intervention on the monitoring sheet...N. It is the responsibility of the Clinical Nurse Manager to ensure Licensed Nurses are completing the Behavior/Intervention Monthly Flow record correctly...." 3.1-48(a)(3)		1. Audit by the Director of Nursing or designee of behavior flow record completion to be completed daily x 5 days, 3 x per week x 2 weeks, weekly x 2 weeks, then monthly x 3 months. Audit will then be quarterly until compliance has been achieved per Quality Assurance Performance Improvement Committee. 2. Facility will be converting to Electronic Medical Records November 3rd, 2015 and behavior flow records will be a part of this new system.	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure a resident's room and in several areas	F 0465	Corrective Action: 1. Flooring in bathroom of Room A was removed and new vinyl sheet flooring was installed 10.14.15. by	11/07/2015

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	were free of odors for 1 of 42 resident rooms, which was observed for odors (Resident J) and the environment was not debris free adjacent to residents' rooms for 1 of 2 water heater closets on the Bridge Unit. (North Bridge Unit side) Findings include: 1. Resident J's record was reviewed on 10/8/15 at 11:39 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances and alcohol abuse. A Physician progress note dated 12/18/14, indicated the resident urinated in the closet. A Physician progress note dated 4/8/15, indicated the resident "Still urinated and defacating in strange places. Moved to his own room. Mostly confined to room." A Care Plan Conference Summary dated 6/1/15, indicated the resident was incontinent of his bladder and voided in inappropriate places. A Physician progress note dated 6/11/15, indicated the resident had dribbling and incontinence.		the Plant Operations Director (See receipt) 2. Water heater room of the north Bridge Unit was painted by the Plant Operations Director with “Kilz” 10.22.15. Door frame was painted with “Kilz” 10.22.15. How Others Identified: 1. Audit by the Housekeeping Director was conducted of bathrooms throughout the entire facility for bathroom flooring was free from odors and none were found. 2. An Audit by the Plant Operations Director was conducted of Water Heater rooms for black substances. None found. Preventative Measures: 1. All facility bathroom audits for odors will completed by the Housekeeping Director daily for 5 days, weekly for 4 weeks, then monthly until there are two consecutive months of 100 % compliance. Then quarterly thereafter. Audit results will be submitted monthly to QAPI for monitoring, further interventions and follow up. 2. All water heater room audits will be completed by Plant Operations Director or designee daily for 5 days, weekly for 4 weeks, then monthly until there are two consecutive months of 100% compliance. Audit results will be submitted monthly to Qulaity Assurrance Performance Iimprovement Committee for monitoring, further interventions and follow up. Monitoring: Plant Operations will submit the results of the audits to the Quality Assurance/	

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	A Physician progress note dated 8/12/15, indicated the resident had dribbling and incontinence. A Care Plan Conference Summary dated 8/27/15, indicated the resident had occasional incontinent bladder episodes and voided in inappropriate places. On 10/7/15 at 3:25 p.m., when entering the Bridge Unit (Alzheimer's Unit) a urine odor was observed. On 10/7/15 at 3:37 p.m., when entering Resident J's room with the Plant Operations Director (POD) and the Housekeeping Manager (HM) in attendance, a urine odor was noted when the door to the room was opened. As the room was entered, the urine odor became stronger. The resident's floor was observed to be slick and the HM's shoes slid on the resident's floor without the floor being wet. The HM indicated at that time the resident's floor felt as if it had a "wet liquid" on it when she stepped in front of the closet door. The closet door was opened and a stronger odor of urine was noted. During that time the POD indicated the resident urinated in the closet at times. He indicated he knew the room had a urine odor, but he did not know the room had a strong urine odor. He indicated he had made rounds and		Performance Committee monthly for monitoring, follow up and further interventions	

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	came into that room approximately two to three weeks ago and he had smelled urine, but it had not smelled that strong. He indicated he had contacted Housekeeping to clean the room at that time, but he had not been back in the room since then. He indicated the nursing and housekeeping staff who had been going in and out of the resident's room should have notified him or the HM regarding the strong urine odor. On 10/7/15 at 4:45 p.m., the Administrator indicated he was aware of the strong urine odor in Resident J's room. He indicated the type of flooring that was used in the residents' rooms had creases in it and when the resident urinated on the floor the urine seeped down under the flooring and that was where the urine odor came from, so the whole flooring had to be replaced. On 10/8/15 at 11:39 a.m., a urine odor was noted when walking onto the Bridge unit. Resident J's room door was observed open and a very strong urine odor was noted walking past the room and while sitting at the nurse's station, which was located right next to Resident J's room. During an interview on 10/8/15 at 11:57 a.m., CNA #5 indicated Resident J was			

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	not incontinent and he wore male underwear. He indicated the resident would "undo" his pants and urinate onto his room floor and in his closet, but not all the time. During an interview on 10/8/15 at 12:12 p.m., RN #6 indicated Resident J urinated on the floor around the toilet at times and he had a history of urinating in the closet, on his floor and in his drawers. She indicated he wore his own underclothing, he ambulated on his own and toileted himself. 2. On 10/7/15 at 3:26 p.m., the North Bridge Unit water heater closet had three walls above the water heater, which were observed to have multiple dark gray/black shadows beneath a white colored coating. The Plant Operations Director (POD) indicated approximately three to four weeks ago the water heater water pipes busted, leaked and sprayed water on the walls above the water heater. He indicated the closet was humid and mold grew on the walls. He indicated he used Kilz (a primer product, which sealed surfaces before paint was applied) on the three walls. He indicated he placed Kilz on the walls to kill the mold. The POD indicated he needed to paint the walls, but he had not gotten time to get back around to painting the			

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	walls with paint yet, indicating that was the reason for the dark gray/black shadows observed beneath the white Kilz coat. On 10/7/15 at 4:45 p.m., a black substance was observed on the top of the door frame and the top of the closet door of the North Bridge Unit water heater closet door. The Administrator indicated the black substance was a "black substance." On 10/7/15 at 4:55 p.m., the top of the door frame and door of the North Bridge Unit water heater closet door was observed to have smeared black marks on them. The Administrator indicated at that time the "black substance wiped off with a rag and water." During an interview on 10/8/15 at 9:33 a.m., the POD indicated he had forgotten to indicate he had bleached the three walls in the North Bridge Unit water heater closet and let them dry for two days prior to applying the Kilz on them three or four weeks ago. On 10/8/15 at 9:49 a.m., a can of Zinsser Primer was observed, the can label indicated the substance was a primer for mold and mildew resistant film and sealed walls uniformly and blocked			

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	155378	A. BUILDING 00 B. WING	10/08/2015

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	stains. The POD indicated he had used this product instead of Kilz to treat the North Bridge unit water heater walls, but it was the same substance as the Kilz, it was a different brand name. He indicated he might have missed that "black substance" on the top of the door frame and closet door three to four weeks ago when he treated the three walls. This Federal tag related to complaint IN00180504 and IN00181061. 3.1-19(f)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure Inventory of Personal Effects lists were present and complete for 3 of 3 residents being reviewed for accuracy of clinical records.	F 0514	**1. How will the corrective action(s) be accomplished for those residents found to be affected by the same deficient practice?**	11/07/2015

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	(Residents Q, C and T) Findings include: 1. Resident Q's record was reviewed on 10/5/15 at 9:59 a.m. The resident's record lacked an "Inventory of Personal Effects" list. During an interview on 10/6/15 at 5:00 p.m., the DON indicated the resident's record did not have an "Inventory of Personal Effects" list to indicate where the resident's belongings were sent upon discharge. 2. Resident C's record was reviewed on 10/5/15 at 2:11 p.m. The resident's "Inventory of Personal Effects" list was signed on the Admission/Move in area at the bottom of the list dated 3/13/15. The list lacked a signature from a facility staff member and Resident/Responsible Party on the Discharge/Move out area at the bottom of the list. During an interview on 10/8/15 at 4:10 p.m., the Director of Nursing (DON) indicated she could not find a signature by a staff member or Resident or Responsible party on the "Inventory of Personal Effects" list to indicate where the resident's belongings were sent upon discharge.		The affected resident has been discharged; no corrective action is able to be done at this time. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** 1. An audit of all admissions from August 1st, 2015 – October 8th, 2015 will be conducted Medical Records. **3. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not reoccur?** 1. Upon admission the Certified Nursing Assistance. will provide the family with the Inventory Sheet to start listing items brought in. 2. The next dayshift after admission the Certified Nursing Assistant (C.N.A.) will review the inventory sheet with the resident/responsible party and collect signatures. 3. 48 hours after the admission, Medical Records	

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	3. Resident T's record was reviewed on 10/8/15 at 2:09 p.m. The resident's "Inventory of Personal Effects" list was signed on the Admission/Move in area at the bottom of the list dated 9/5/15. The list lacked a signature from a facility staff member and Resident/Responsible Party on the Discharge/Move out area at the bottom of the list. During an interview on 10/8/15 at 4:45 p.m., the Director of Nursing (DON) indicated she could not find a signature by a staff member or Resident or Responsible party on the "Inventory of Personal Effects" list to indicate where the resident's belongings were sent upon discharge. This Federal tag relates to Complaint IN00183674. 3.1-50(1) 3.1-50(2)		Director will audit the chart including the inventory sheet. A copy of the audit will be provided to the DON/Designee. 4. Upon discharge Charge Nurse to ensure the Discharge Summary and the Inventory Sheet are both signed by the resident or responsible party. **4. How will the facility monitor its performance to make sure that solutions are sustained; that the plan is implemented and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?** 1. A chart review (including inventory sheet) will be conducted by the Unit Manager within 72 hours of admission. 2. Chart Audit (including inventory sheet) to be completed at day 14. 3. A copy of the chart audit will be provided to the Director of Nursing or designee on day 15. 4. An audit of all residents'	

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			inventory sheets will be conducted and updated as necessary. **5.** An audit by the Director of Nursing or designee of discharged residents will be conducted to ensure compliance with signatures of inventory sheet and discharge summary. Results of the audit will be submitted to the Quality Assurance Performance Improvement Committee for monitoring, follow up and further Intervention. Audit to be completed on all discharges x 1 month, then quarterly until Quality Assurance Performance Improvement compliance has been met.	